



Women, Pregnancy and Substance Misuse: Good Practice Guidelines

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Policy Reference: 020219	Date of Issue: July 2015
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Ratified by: NMAHP Policy, Procedures & Guidelines Ratification Group	Date Ratified:
PFF: Yes	Date PFF: June 2015

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Foreword

The foundations for health and wellbeing are established in the earliest moments of life and pregnancy offers an opportunity for services in Highland to provide effective intervention to ensure the best possible care is provided to promote the wellbeing of women and their infants pre-birth, throughout pregnancy and into parenthood. However, a significant number of children will have their health and wellbeing affected by their parents' use of substances (Scottish Executive 2006). Moreover there is growing evidence that there is a relatively narrow window of opportunity for intervention in a child's early years: lack of adequate nurture is likely to have a long-term damaging effect, with children more likely to have poorer health and wellbeing outcomes.

Women who misuse substances and their infants have better outcomes if they take up antenatal care early and if they use services consistently throughout pregnancy. Pregnancy may motivate many women to access support for substance using issues but some may feel inhibited due to feelings of guilt or fear that their children may be removed from them. Services therefore need to be accessible, welcoming and empowering for those women affected by substance use, just as they do for others.

The detail in this guidance represents best practice for maternity staff across Highland however, other services involved with pregnant women who use substances have a critical role to play in supporting women and will find this guidance useful.

Health inequalities and social exclusion have an impact on health and wellbeing and it is essential that evidence based information and support provided through integrated working that is based on individual need, is provided to all women (NHS QIS 2009). This equally applies to women who have problems with drug or alcohol misuse, who require access to a full range of services within a multidisciplinary assessment process.

Good practice in maternity care can help to ensure the early links with families enables everyone to work together to provide a coherent and responsive service.

“Women, their partners and their families should always be treated with kindness, respect and dignity. The views, beliefs and values of the woman, her partner and her family in relation to her care and that of her baby should be sought and respected at all times.”

(NICE 2008).

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Summary of Guidelines

- Pregnant women who misuse substances should be managed according to best practice as stated in Getting Our Priorities Right: Updated good practice guidance for all agencies working with children, young people and families affected by problematic alcohol and/or drug use (Scottish Government April 2013).
- Staff who are taking a booking history should always ask sensitively but routinely about all substance misuse. The Scottish Woman Held Maternity Record (SWHMR) contains specific questioning relating to the use of tobacco, alcohol and prescribed or illicit drugs.
- When appropriate, staff should deliver a 'brief intervention' regarding smoking or alcohol use. If required, women can be referred for specialist smoking cessation support or additional support from specialist alcohol/drug services.
- Information on any social issues that could impact on outcomes of the pregnancy, including substance misuse, should be documented in the SWHMR and summary sheet. The Highland Practice Model (GIRFEC) should be used to enable robust assessment and planning of care for women and their babies.
- There are challenges for service providers to engage with women whilst balancing the needs of their children. Obstetricians, midwives and addiction services need to be aware of the laws and issues that relate to child protection. If they have any concerns they must refer to the Highland Child Protection Guidelines or contact their designated Child Protection Advisor (CPA) for advice.
- All staff supporting pregnant women that have drug or alcohol problems, including obstetricians, GPs, midwives, health visitors (HV), social work staff and addiction services, require on-going training to ensure they have the knowledge and skills required to identify problems, assess severity and the impact on children.
- Women who have misused alcohol and/or drugs within the 12 months prior to their pregnancy will follow a Red Pathway - *Pathways for Maternity Care* (NHS QIS, 2009) and will require review by an obstetrician and individual care planning by the wider Maternity Team.
- Pregnant women who have significant drug and/or alcohol use may also have other social problems and their care should reflect this. They should not be managed in isolation but by maternity services that are part of a wider multiagency network, which should include both addiction and social work staff.
- The management of women who have substance misuse and mental health co-morbidity requires close supervision by specialist services during pregnancy.
- Women who are opioid users should be prescribed appropriate substitution therapy during pregnancy.
- Close follow up and multiagency support in the postnatal period is essential for women and their babies, as relapse can be a problem at this time. This is captured within the

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Health for All Children (Hall 4) programme and Highland Practice Model (GIRFEC) where women who misuse substances will be assessed as requiring additional/intensive support from services.

- Substance misuse may be associated with past or current experiences of violence or abuse and with psychiatric or psychological problems. All staff must remain aware of this and support families appropriately.

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1. Background

We live in a drug using society. Heroin, tobacco, prescription medicines, alcohol, cannabis and caffeine are all drugs. Almost all of us use drugs every day or every week, and in the majority of cases the substances we use are legal and the way in which we use them does not cause problems for ourselves or others.

However, for some in society, substance use creates significant problems in functioning and in their ability to manage their day-to-day life, employment, parental and family responsibilities. The challenge for services and professionals is to be sensitive to the needs of women whilst being vigilant to the possibility that a woman may be using substances in a way that may cause harm to herself, her developing baby or a child in her care. Ensuring that services do not undermine a woman's confidence to handle her situation or make her reluctant to disclose or come forward for help in the first place can help improve outcomes for her and her children.

These guidelines were first produced in 2009 and have been revised bi-annually since then in line with current legislation and national policy to support professionals within the maternity and drug services in Highland to assist them in providing optimal care to this client group. They should be used alongside other documentation, policies and good practice guidelines already in place which support pregnant women. They are designed to clarify information about:

- The implications of substance use in pregnancy
- Support available to women and their families
- The most appropriate pathways

The interests of a child and its mother are inextricably linked and maternity services and those who are helping the parent with their substance use must work closely together. The Scottish Government national Early Years Collaborative has been developed to ensure the recommendations of the Early Years Framework (Scottish Government 2008) and GIRFEC are enacted and recognise the impact that our experiences both pre-birth and during the early years have on not only childhood but longer term into adulthood.

Providing an early intervention, preventative and multiagency approach where additional needs are identified will provide the best chance of success in addressing health inequalities. The Highland Practice Model (GIRFEC) offers practitioners across all agencies in Highland the foundations to enable robust assessment and planning of care within a health and social context.

The planning for Fairness process has been applied to these guidelines to ensure that they address equality and diversity considerations.

Thanks to all who have contributed to the revision of the Guidelines, their names appear in Appendix 5.

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2. Helping people to change: principles of health behaviour change

Encouraging people to take responsibility for their own health and providing them with skills to allow them to make positive changes to their lifestyle are key to a health improvement approach. This approach is very useful when working with people who are attempting to address their smoking, alcohol or drug use.

Changing behaviour is not easy. Even when we make choices, making change takes commitment, confidence and often support. It takes time to make changes and we tend to resist being told what to do. We may know many of the reasons for change already, but may need information relevant to our own lives at times which suit us.

Motivational interviewing recognises:

- Making change is a process which tends to take place over time, and a health professional may play only a small, although significant, part in that process. Most people will make these changes by themselves however, some need assistance.
- It's a normal human reaction to want to solve others' problems and practitioners often slip into the advice-giving and directive mode known as the 'Righting Reflex'. However, the result is usually resistance as control has been taken away from the person.

The role of the practitioner in negotiating change with women and families is to:

- Act as a guide, helping them to find their own motivation and confidence to change
- Help resolve the ambivalence they may have about changing
- Support them to identify solutions and create a realistic plan

The key principles of motivational interviewing should underpin all good practice in supporting people to make changes. This makes the whole experience less frustrating for both client and practitioner and can lead to more sustained long-term outcomes of change.

Key principles of motivational interviewing:

- Collaboration: the engagement and involvement of women as partners and decision-makers is key
- Express empathy and establish rapport
- Evoke or elicit the case for change from the woman rather than provide it, although the practitioner can offer information which may guide this. Ask permission to give information or feedback.
- Respect the autonomy of women, don't take control. A woman may not be ready to change, and moving forward and taking action too quickly may only cause resistance. Practitioners must constantly assess readiness to change.
- It is normal to feel in two minds, or ambivalent, and a practitioner can help a woman to explore and hopefully resolve this ambivalence by asking them how important they think the change is, and how confident they feel to take it forward. These two elements indicate motivation and thus readiness. Eliciting and listening for change talk is the practitioner's task.

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- Only when a woman is ready to change does the practitioner move on to support change planning, ensuring that they identify specific goals and the steps to take.
- Support self-efficacy. This is a woman's confidence and belief in her ability to do something-to be competent. This is a key indicator of change, and it should be nurtured and supported. The practitioner's role is to support a sense of hope.
- If faced with resistance, do something differently and in particular show that you are listening by reflecting back what seems to lie behind the woman's expression of resistance. Emphasising personal responsibility is also a useful tactic. Most of all, recognise that resistance is in some ways a message to the practitioner that they are doing something wrong.
- Remember inequalities, and the need to address life circumstances. Working with women is only one way of encouraging change.

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3. Smoking

Smoking in pregnancy remains a major preventable cause of maternal and fetal mortality and morbidity. Assisting women to stop smoking before and during pregnancy must remain a priority for maternity services. Midwives have a responsibility to ensure that they have the training and expertise to raise the issue of smoking with all pregnant women and the knowledge of how to refer on to specialist services.

3.1 Harm caused by smoking

There is robust and constantly emerging evidence to support the harm that continued smoking in pregnancy brings to the mother and her developing baby resulting in considerable childhood morbidity in later years and subsequent generations (Surgeon General's Report 2014) these include:

Effects on Women	Effects on babies
<ul style="list-style-type: none">• Placenta Praevia• Placental abruption• Premature rupture of membranes• Ectopic pregnancy• Infertility	<ul style="list-style-type: none">• Stillbirth• Sudden Infant Death Syndrome• Premature Delivery• Intrauterine growth retardation• Infant death• Cleft lip/palate

Smoking in pregnancy is also strongly implicated in causing:

- Club foot
- Gastroschisis
- Heart defects
- Attention Deficit Hyperactivity Disorder (ADHD)
- Miscarriage

(Hackshaw, Rodeck, Boniface, 2011)

Accurate recording of smoking status in pregnancy forms an important part of the risk assessment. Smoking 11 or more cigarettes per day equates to a major risk factor thus requiring serial growth scans and assessment of fetal wellbeing with Umbilical Artery Doppler from 26-28 weeks until delivery. Smoking 10 or less cigarettes per day is allocated a minor risk factor. If a woman has 3 or more minor risk factors they will require UTERINE artery Doppler studies at 20-24 weeks (NHS Highlands 2015) The accuracy of CUB(combined ultrasound and biochemical) screening also depends upon truthful recording of smoking status required to calculate risk.

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3.2 Prevalence and reporting

Interpreting smoking data can be difficult as evidence suggests that self-reported smoking can be underestimated by up to 25% by pregnant women Shipton D, Tappin D et al (2009). The disparity in smoking rates found in pregnant women living the least deprived and the most deprived areas of the Highlands continues with only 8% pregnant smokers found in the least deprived quintile (5) rising to 40.3% pregnant smokers in the most deprived quintile (ScotPho 2013).

Nationally 38.6% of young women under the age of 20 years are much more likely to smoke compared to 11.5% of those over the age of 35 years (ISD 2013). This highlights the need to particularly target efforts at young mothers living areas of deprivation.

Smoking Prevalence in NHS Highland compared to Scotland source ISD and SMR02

NHS Board of Residence	2013		2012		2011		2010	
	Current %	Not Known %	Current %	Not Known %	Current %	Not Known %	Current %	Not Known %
Highland	19.4	3.1	18.7	2.1	20.0	2.2	22.1	3.7
Scotland	18.4	4.6	19.3	5.3	19.2	4.8	18.8	10.6

3.3 Carbon Monoxide Monitoring

Nice Public Health Guidance 26 (2010) recommends measuring expired Carbon Monoxide (CO) levels in all pregnant women. This should improve underreporting, increase referrals into smoking cessation services and ultimately reduce smoking prevalence in pregnant women.

CO is a poisonous gas and one of the 4000 chemicals which are absorbed into the blood stream via inhalation of tobacco smoke, it crosses the placenta, is absorbed by the fetus and harms both placental function and the developing baby.

All pregnant women presenting at 1st booking in NHS Highland should be offered CO testing by their community midwife regardless of smoking status. Any woman with a CO \geq 4ppm, a current smoker, recent quitter or has a household member who smokes should be encouraged to accept referral to smoking cessation services as outlined in the referral pathway – Smoking Cessation Maternity Referral Pathway

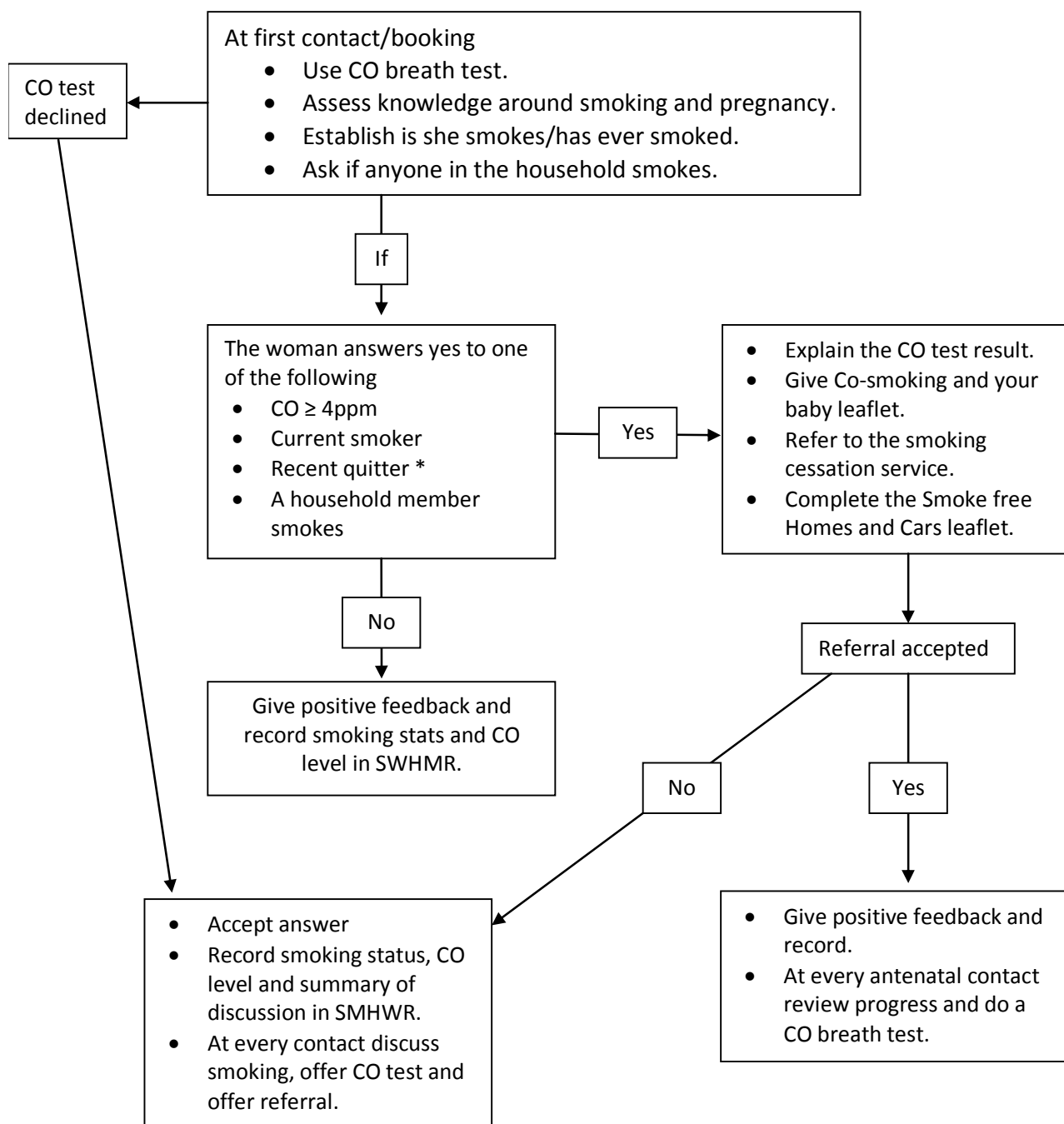
NB.

*Recent quitter is someone who has quit after confirmation of pregnancy or in the last 2 weeks

A small number of women will have a CO \geq 4ppm and not smoke or be exposed to second hand smoke. It is important to reassure these women that this will not harm their baby, the level is set at 4ppm for referral and screening purposes. They can still be referred to the Smoking Cessation Midwife for further information and advice. If their CO is 10ppm or above then advise contacting the Health and Safety Executive gas safety line on 0800 300 363 for advice on checking heating systems.

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NHS Highland Smoking Cessation Maternity Referral Pathway



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3.4 Raising the issue of smoking in pregnancy

Discussing smoking in pregnancy can be a sensitive issue as many women are reluctant to discuss their smoking status due to guilt and low confidence of ability to quit. Midwives have in the past been worried that it may damage their relationship. It is vital that the issue is raised so that a frank discussion can take place ensuring that the risk of continued smoking is fully understood by women allowing them to make an informed choice based on robust evidence and that they are aware of the support available to them.

One of the best ways to raise the issue and assess her knowledge of harm caused is to ask what she knows or has heard about smoking in pregnancy. Asking permission to give advice has also been shown to be well received. Any partners and family members present should also be included in discussions and referral to smoking cessation services offered to them if appropriate. The use of open questions can aid and initiate discussion particularly if it is backed up by reflective listening skills. Some examples of motivational questions are:

- What have you heard about smoking in pregnancy?
- Can you tell me why you've wanted to cut down?
- Can you imagine how it would be for you if you stopped smoking?
- What are your thoughts around getting some help with your smoking?
- What made you want to try stopping before?
- It sounds like you have a fair bit of knowledge around smoking in pregnancy; would it be ok to tell you what I know, fill in the gaps?

3.5 Smoking cessation

Stopping smoking in pregnancy particularly before the end of the first trimester can significantly reduce the harm caused to mother and baby (McCowan, et al 2009) and lower health care costs associated with poor obstetric outcomes. All Midwives have a responsibility to raise the issue of smoking in pregnancy and ensure that women and their partners are fully aware of the risks associated with smoking in pregnancy allowing them to make an informed choice. Referral to specialist smoking cessation services can double the chances of successfully quitting.

NHS Highland has a Specialist Smoking Cessation Midwife and Generic Smoking Cessation Advisors covering all geographical areas. Contact details of the advisors can be found at this link www.smokefreehighland.co.uk/contact-us-3/ as well as information and advice for both women and professionals. Referrals can be phoned, emailed or posted and should be made as early as possible in pregnancy as outlined in the Smoking Cessation Maternity referral pathway (page 11).

Contact: Smoking Cessation Midwife, Ward 9, Maternity Unit, Raigmore Hospital, Inverness.
Tel: 01463 706370. Mobile: 07824417514.

Motivation to quit can vary throughout pregnancy therefore women who continue to smoke should be offered CO testing at each antenatal appointment and the offer of referral reiterated. Women and their families who decline referral to specialist services should also be informed of

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alternative methods of support to include, community pharmacy scheme, written information, national telephone helpline and self-help forums on websites.

Quit attempts by pregnant smokers Source Scottish Public Health Observatory 2015

	2010-2012 3 yr aggregate	2008-2010 3yr aggregate
NHS Highland	27%	20.4%
Scotland	23.5%	19.9%

3.6 Smoke free homes and smoke free cars

Women who are unable or unwilling to quit should be praised in their efforts to ameliorate the effects of smoking whilst highlighting the only way to remove risk altogether is not to smoke. They should be supported in their effort to cut down by referral to smoking cessation services in the hope that it will lead to a full quit.

Pregnant women and their families should be supported and encouraged to reduce the harm caused by exposure to second hand smoke by smoking outside and making their homes and cars smoke free. A pack to support this is available to order via HIRS which contains practical advice to support families in their efforts to achieve a smoke free environment. See Highland Information Trail.

3.7 Training

The smoking Cessation Midwife offers free training in Raising the Issue of Smoking and CO testing. Teams and individuals can request training by contacting her direct, contact details available through this link www.smokefreehighland.co.uk/contact-us-3/

More in depth training in taking a person-centred approach to communication by using motivational interviewing techniques to support people to change their behaviour is available free to staff in NHS Highland. If you would like a bespoke course for your staff group or in a different locality, please get in touch to discuss the details. Courses can be run with shorter sessions over a number of weeks.

Further information can be found under the Public Health area of the intranet or contact 01463 704781. For courses in Argyll & Bute contact 01586 552224 .

3.8 Nicotine replacement therapy (NRT) and pharmacotherapies

- The use of nicotine replacement therapy to assist a quit attempt in pregnancy is preferable to continued smoking but should only be used if smoking cessation without NRT fails and after a risk assessment.
- It should be used at as low a dose as possible for as short a time as possible bearing in mind that pregnant women metabolise nicotine faster than the general population.
- Intermittent methods such as gum, lozenge, spray and inhalator are preferred to patches but liquorice flavours should be avoided.

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- Patches can be used if women are unable to tolerate oral methods due to nausea but should be removed before sleeping at night.
- Women should be reminded not to smoke concurrently whilst using NRT(BNF 2014).
- Varenicline (Champix) and Buproprian (Zyban) are medications which reduce cravings associated with stopping smoking they are **both contraindicated** in pregnancy and should be avoided. They may be suitable for partners and other family members.

3.9 Electronic cigarettes

Due to a lack of evidence that the use of e-cigarettes aids smoking cessation and concerns over safety of long term use these devices **should not** be recommended to pregnant women. Smokers who are using an electronic device should be offered referral to smoking cessation services rather than recommended to return to smoking.

Scottish Directors of Public Health strongly advocate that e-cigarettes should be treated in the same way as normal cigarettes within NHS Tobacco policies:

- The use of e-cigarettes in NHS grounds perpetuates the idea that smoking is normal behaviour and acceptable in public areas.
- Patients, visitors and staff may be confused by the similarity of e-cigarettes to normal cigarettes and may mistake them for real cigarettes. This will hamper the implementation of NHS Tobacco Policies.
- The risks to health from the inhalation of e-cigarettes are unknown. These devices are currently unregulated and may contain varying amounts of nicotine and other contaminants particularly risky for pregnant women.
- The health and safety risks from using these e-cigarettes are also currently unknown; there have been reports of faulty chargers exploding.
- The potential for e-cigarettes to be a tool in a harm reduction regime for smokers is still under consideration. However, evidence-based NRT products are used to assist those who wish to stop smoking and can be used when people are visiting NHS premises.
Highland formulary (2015)

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4. Alcohol

No safe level of alcohol use has been established in pregnancy, NHS Highland therefore supports the view that: **Women who are pregnant should avoid drinking alcohol.**

Rationale

NHS Highland's decision to recommend abstinence as the safest approach is the advice that should be given to pregnant women. It avoids inconsistencies of promoting abstinence and then qualifying this advice with possible discussion related to limiting intake to 1 to 2 units once or twice per week. In order to avoid any confusion for pregnant women and due to the limited awareness of alcohol units generally across society, staff are directed to promote clear and consistent advice that **the safest option is to abstain from alcohol throughout pregnancy as no safe limit has been established.**

Health Risks

Alcohol is a teratogenic compound - a substance that can interfere with the normal development of the baby that readily crosses the placenta. In the absence of a developed blood filtration system, the baby is unprotected from alcohol circulating in the blood system. The effects of alcohol consumption during pregnancy have been extensively studied and it is widely accepted that consumption of alcohol by women during pregnancy may result in adverse effects on the child's health and wellbeing after birth.

Alcohol consumption during pregnancy can increase the risk of:

- Miscarriage
- Low birth weight
- Pre-term labour
- Fetal Alcohol Syndrome (FAS)
- Fetal Alcohol Spectrum Disorders (FASD)

4.1 Prevalence of alcohol consumption in pregnancy

National UK data shows less women drinking in pregnancy than previously

In 2010, two in five mothers (40%) in the UK drank alcohol during pregnancy, which was fewer than in 2005 (54%). Mothers aged 35 or over (52%), mothers from managerial and professional occupations (51%) and mothers from a White ethnic background (46%) were more likely to drink during pregnancy. Mothers in England (41%) and Wales (39%) were more likely to drink during pregnancy than mothers in Scotland and Northern Ireland (35% in each).

Of those who continued to drink, 3% consumed on average 2 or more units of alcohol a week

<http://www.hscic.gov.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf>

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Women and alcohol

The female drinking culture has changed over the past two decades. Revised estimates from the Scottish Health Survey suggest 18% of women exceed the weekly benchmark of 14 units. Of these, 30% consume above the daily limits (>3 units) on their heaviest drinking days. In addition, 43% of 16 – 24 year olds are likely to binge drink which is concerning due to the role alcohol can play in sexual risk taking and the subsequent link with pregnancy.

The update also found that adults from professional and managerial groups with higher incomes were more likely to drink alcohol above recommended limits.

4.2 Fetal Alcohol Syndrome and Fetal Alcohol Spectrum Disorders

Fetal Alcohol Syndrome (FAS) is a condition that affects the development of a baby's brain in utero due to maternal alcohol consumption. It causes severe physical and mental problems for the child and affects about 1-2 in every 1000 babies. It is 100 % preventable – no alcohol consumption, no FAS.

Babies born with FAS can be quite easily identified due to their distinguishable facial features including: small and narrow eyes, a small head, a low nasal bridge, a smooth area between the nose and the lips and a thin upper lip, and their ears may be set lower. They may be born with low birth weight and remain small compared to their peers. Each child with FAS may have some or all of a spectrum of mental and physical birth defects in varying degrees from mild to very severe, with all the challenges they may bring.

Much of the damage to a baby from alcohol occurs early in pregnancy so women who are considering pregnancy must be advised to abstain before contemplating pregnancy. Continued exposure compounds the problems. The clinical features are:

Mental Challenges	Physical Challenges
<ul style="list-style-type: none">• Intellectual disability: lowered IQ• Poor memory• Learning ability• Attention disorders• Sensory impairment• Speech and language problems• Mood disorders• Behavioural problems• Autistic-like behaviours• Sleep disorders	<ul style="list-style-type: none">• Visual and eye defects• Hearing and ear defects• Mouth, teeth and facial defects• Weak immune system• Epilepsy• Liver damage• Kidney defects• Heart defects• Cerebral Palsy, muscular defects• Height and weight deficiencies• Hormonal disorders• Skeletal defects• Genital defects

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Fetal Alcohol Spectrum Disorder (FASD) is the umbrella term used to describe the conditions that occur in people who have been diagnosed with some, but not all, of the features of FAS. Like FAS, FASD is caused by a mother's drinking during pregnancy, and it affects the way a baby develops physically and mentally. There are no accurate records of the incidence of FASD in Western countries, but experts estimate that it may be 10 per 1000 or higher.

It is more difficult to diagnose FASD than it is FAS because children with FASD may not have any facial deformities. It might not be until they start interacting with others or going to school that the following symptoms become apparent:

- Learning difficulties
- Problems with language
- Lack of appropriate social boundaries (such as over friendliness with strangers)
- Poor short term memory
- Inability to follow instructions
- Failure to learn from the consequences of their actions
- Self-absorption
- Mixing reality and fiction
- Difficulty with group social interaction
- Poor problem solving and planning
- Hyperactivity and poor attention
- Poor coordination

Often FASD is undiagnosed or misdiagnosed, for example as autism or attention deficit hyperactivity disorder (ADHD). Early diagnosis is vital to ensure appropriate treatment and support systems are in place at the earliest opportunity (BMA 2007).

By the time children with FASD reach their teenage years they may be more susceptible to peer pressure and therefore participate in more risk taking behaviours. They can also be more easily sexually exploited than their peers, experience difficulty getting and keeping employment, and may have problems with alcohol and/or drugs.

A leaflet for women explaining the risks in pregnancy has been developed by the Highland Drug and Alcohol Partnership (HDAP) should be given to women contemplating pregnancy - *Alcohol and pregnancy don't mix* available in the HIRS library as detailed in the Highland Information Trail (2015) Also, the leaflet *Help you keep your baby safe and healthy* should be given to women who are drinking at booking.

The Scottish Government FASD Awareness Toolkit will be useful for all staff to enhance knowledge.

<http://www.gov.scot/Resource/0043/00435992.pdf>

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Proactive approach

Emerging evidence on the risks of alcohol to the developing baby, debate on the unknown impact of small amounts of alcohol, prevalence of alcohol consumption during pregnancy and female drinking patterns all support the need to take a proactive approach to promoting abstinence.

An alcohol brief intervention should therefore be delivered to all women consuming alcohol during pregnancy and those who report pre-pregnancy levels over 14 units a week unless in the practitioner's clinical judgement there are signs of dependency. Where dependency may be an issue the woman should be referred on to a more specialist service for appropriate assessment and support.

4.3 Alcohol Brief Interventions (ABIs)

An alcohol brief intervention provides a structured approach to discussing alcohol use and enhancing the woman's motivation to make changes. The key stages of an alcohol brief intervention (ABI) use motivational interviewing approaches. Current practice in antenatal settings already includes enquiries about alcohol consumption with the Scottish Woman Held Maternity Record (SWHMR) including questions and recommending an ABI.

2% of all ABIs in the NHS Highland area were delivered in an antenatal setting in both 2012/13 and 2013/14. Work is ongoing to increase the confidence and skills of midwives to deliver ABIs and embed them into routine practice

<https://isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2014-06-24/2014-06-24-ABI2013-14-Report.pdf?93899172545>

Training

Training in ABIs is available on line from Health Scotland
<http://elearning.healthscotland.com/enrol/index.php?id=200>

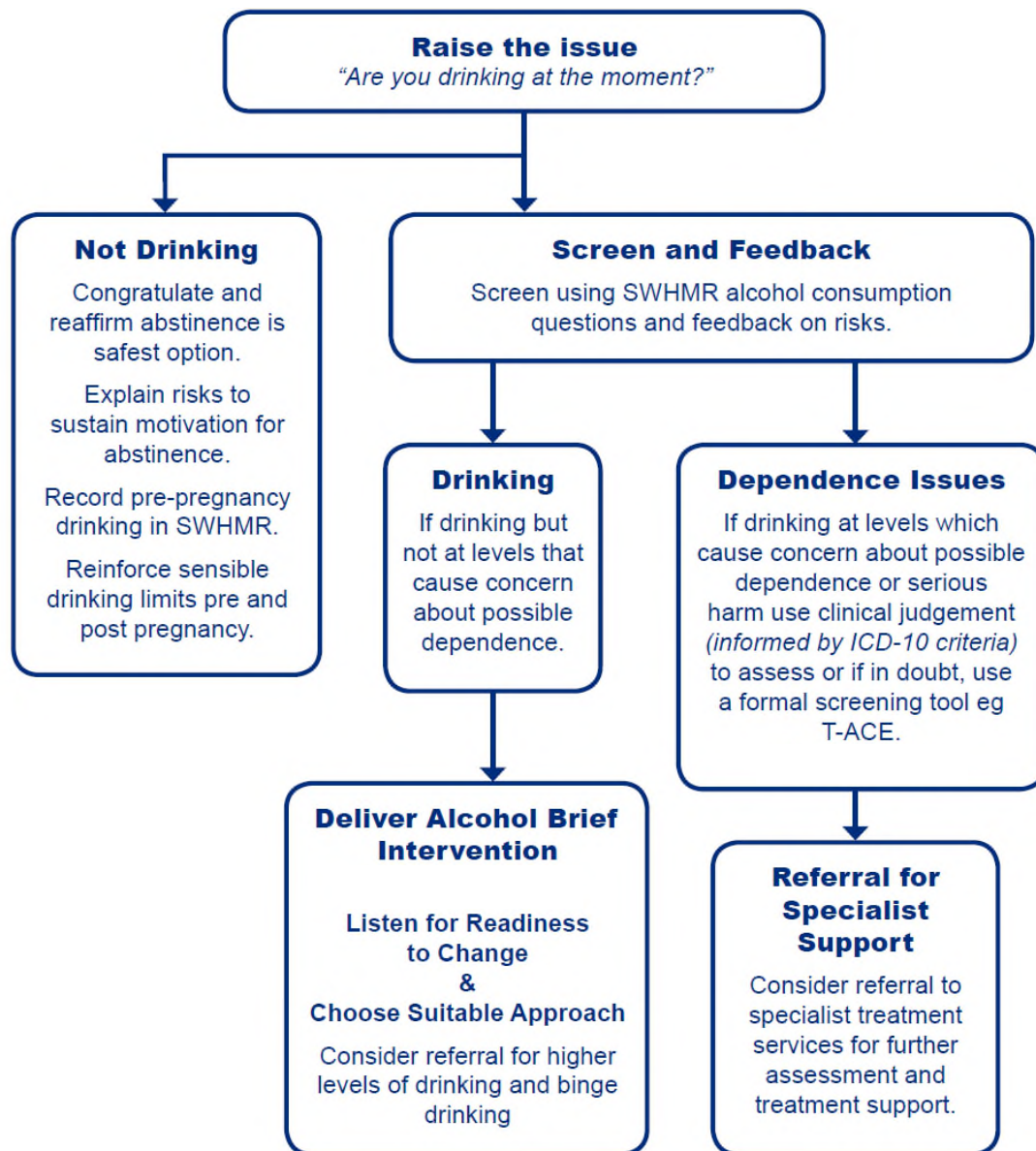
A LearnPro module will soon be available. For further details or contact elspeth.lee@nhs.net

Throughout the brief intervention remember to:

- Maintain rapport and empathy
- Emphasise the woman's personal responsibility

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4.4 Alcohol Brief Intervention Care Pathway



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4.5 Alcohol dependency

If a woman is drinking, at levels which cause concern about possible dependence or serious harm clinical judgement must be used to inform decision making and a formal screening tool can be used e.g. T-ACE.

ICD – 10 criteria for alcohol dependence can also be used to inform clinical judgement. Dependence is diagnosed if three or more of the following have been present together during the previous year:

- Strong desire/ compulsion to drink
- Difficulty controlling drinking onset, termination, level of use
- Physiological withdrawal state
- Evidence of tolerance; increased doses required
- Progressive neglect of alternative pleasures or interests
- Persisting with use despite awareness of overtly harmful consequences

Alternatively the T-ACE screening tool can be used to inform clinical judgement

T-ACE Alcohol Audit Tool	
T-ACE	
T (tolerance) How many drinks does it take to make you feel high? Answer: '3 drinks or more' scores 2 points	
A (annoyance) Have people annoyed you by criticising your drinking? Answer: 'Yes' scores 1 point	
C (cut down) Have you ever felt you ought to cut down your drinking? Answer: 'Yes' scores 1 point	
E (eye-opener) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Answer: 'Yes' scores 1 point	
Total Score	<input type="text"/>
Date of test	<input type="text"/>
Lowest score possible = 0 Highest score possible =5 A total score of two points or more will correctly identify most women whose drinking is hazardous, harmful or dependent.	

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If the T-ACE Alcohol Audit Tool highlights a hazardous score then more detailed advice, information and support should be offered. Specialist referral is recommended for women with harmful alcohol dependence. Osprey House, Community Psychiatric Nurses for Addictions (CPNAs), Community Addiction Nurses and Dual Diagnosis Nurses (substance misuse and mental health) can offer further support and advice to women and other health workers.

An Antenatal Plan: additional support for mother and unborn baby should be completed and risk assessment must include the impact of the alcohol consumption on the baby. Their care should be managed by an obstetrician and provided by the wider maternity care team.

If required, it should be remembered that detoxification for alcohol dependent women should normally be in an inpatient setting to ensure close monitoring of mother and baby (Plant 2001, cited in Whittaker 2003).

In terms of women who choose to breastfeed, they should be informed that alcohol transfers readily into breastmilk therefore **no** alcohol is recommended when breastfeeding. If a mother knows she is going to binge drink then she should be told not to breastfeed until she feels neurologically 'normal' (Hale 2012). However, she should be encouraged to pump her breastmilk and discard to avoid a reduction in supply. A general rule is to assume 2 hours abstinence from breastfeeding for every unit of alcohol consumed

The Health Improvement team have been working with Youth Action Service to support young people under 18 years with 'problematic' substance misuse and contact details for Youth Action can be found in Appendix 1. Drinkline Helpline: 0300 123 1110 can be helpful in supporting women to address their drinking (Mon-Fri 9 am - 8 pm, weekends 11 am - 4 pm)

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5. Drugs

There has been a huge increase in problem drug use both nationally and internationally since the 1980s and this increase has been disproportionately high among women of childbearing age: in the triennial report into maternal deaths in the United Kingdom around 11% women who died had problems with substance misuse (CEMACH 2007). Not all of the women died as a direct result of their drug misuse: substance misusing women were found to have comparatively complex and chaotic lives which greatly increased their vulnerability.

The rate of recorded pregnancies recording drug use in Highland Area & Drug Partnership has decreased between 2009/10 – 2010/11 (9 per 1000 maternities) and 2011/12 – 2012/13 (7.9 per 1000 maternities). Nationally the rate has steadily increased since 2005/06 (ISD Scotland).

Some pregnant women who misuse substances may be frightened of presenting to services for fear of being judged regarding their drug use, yet supporting them in maintaining contact with services is vital. Pregnant women with substance misuse problems should be managed by a team who will provide co-ordinated multidisciplinary and multiagency care. Services should fast-track women into drug treatment services to ensure early intervention and decision making. A non-judgemental, empathic approach will enable them to feel supported in discussing their concerns regarding how their use of substances may impact on their own health and the health of their baby.

Problem drug use is often associated with socio-economic deprivation and maternal health problems including poor nutrition, smoking, alcohol misuse, mental health problems; complications from chronic infection, domestic abuse and homelessness. The effects of drugs on the baby include intrauterine growth restriction, pre-term delivery, increased rates of still birth, neonatal death and sudden infant death (see Appendix 1 – Drugs and their effects on pregnancy). These outcomes are multifactorial and are also affected by socio-economic deprivation. It is therefore essential that a co-ordinated, integrated network of support is in place for all women who require specialist advice or support in pregnancy.

Good maternal history taking is essential to ensure delivery of high quality maternity care. This is a dynamic process which will commence from the woman's first contact with maternity services and continue throughout pregnancy. It should encompass not only physical health but also social circumstances and psychological wellbeing. It is important to ask at booking about drug use, frequency and method of administration and whether more than one sedative drug and medication are used in combination. It is also important to establish if a woman's partner is using drugs or alcohol.

This assessment will better identify:

- If using intravenously, then a multi-agency approach should enable exploration of present injecting techniques, discuss safe practice and provide information on needle exchange. Osprey House, Inverness and Local CPNAs and Locality Teams will assist with this process and women will be encouraged to stop injecting and switch to a safer method. (Appendix 2).
- If they have previously had help and what this involved.
- If they are presently receiving support, are they prescribed any medication and who is prescribing?

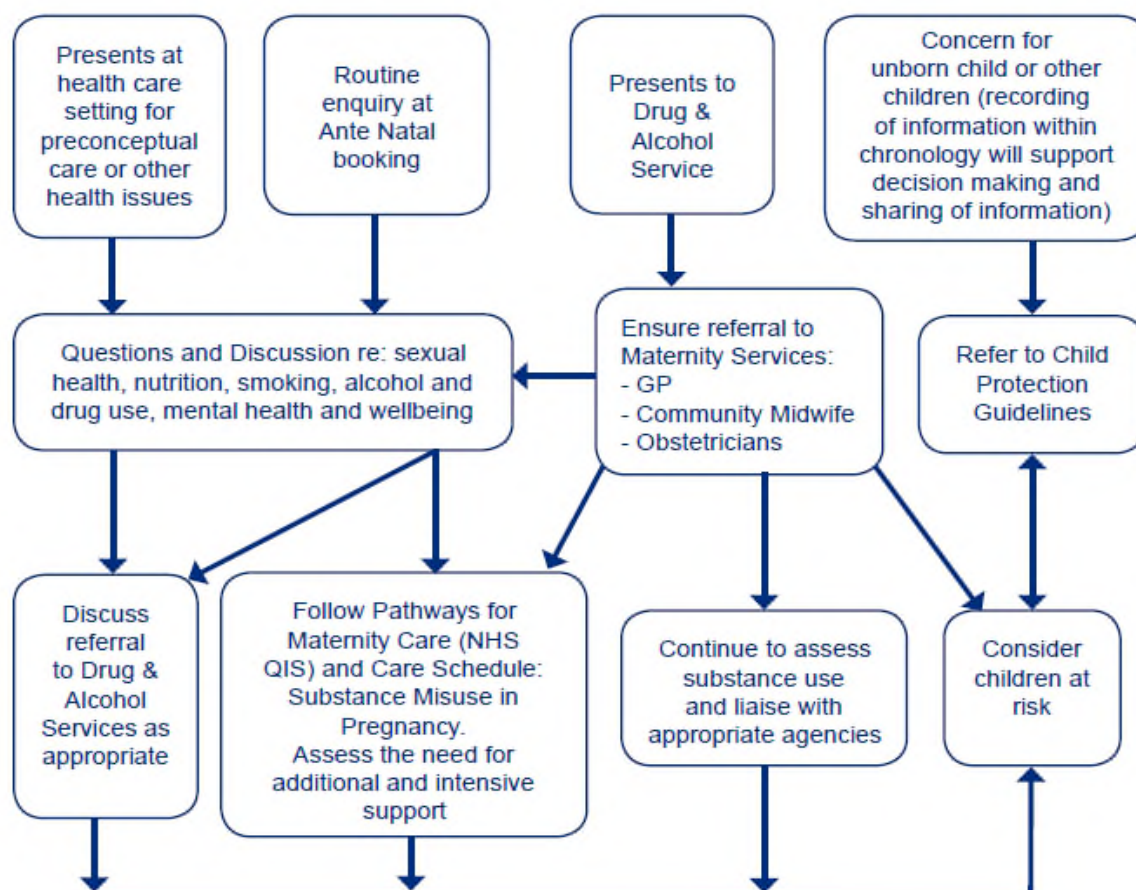
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- If their partner uses drugs; is he/she presently supported with his/her drug use and is engaged in treatment services.
- If a woman is new to substance misuse services, specialist services complete the SMR25a data collection form for ISD
- Assessment and completion of the 'Antenatal Plan' will ensure co-ordination of services and appropriate support is in place for the woman early in pregnancy.
- If the drug (or alcohol) use is likely to impact on the baby or any other children in the family

Women should be encouraged to accept referral to specialist services which can provide a more in-depth assessment of substance use. They can also provide drug screening to confirm present use and offer on-going counselling and support with reducing or stabilising use through substitute prescribing programmes. Osprey House, Inverness can provide this expert advice and guidance for professionals and can be contacted on 01463 716888. Alternatively, staff can contact addiction nurses, along with other agencies who can offer advice and support with regard to substance misuse.

5. 1 Referral pathway when working with women who misuse substances



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The Care Schedule: Substance Misuse in Pregnancy describes a woman's journey through pregnancy and should provide practitioners with more detailed information when planning care for this client group. Pre-birth planning discussions which includes parents, should assess risk, determine outcomes and plan support networks thereby reducing the need for emergency child protection procedures at birth (see Section 7.2 in 'The Woman's Journey').

5.2 Substitute prescribing in pregnancy

Substitute prescribing can occur at any stage during pregnancy and the risks to mother and fetus are lower than continuing illicit drug use. It promotes engagement with services and assessment of health and social needs.

Within Highland the medication of choice during pregnancy is Buprenorphine (Subutex) as evidence suggests that it is associated with better neonatal outcomes. Buprenorphine has been evidenced as having less neonatal withdrawal symptoms (Jones et al 2011). Methadone has been linked with visual disorders in infants (see Appendix 1). Where a client is already prescribed Methadone they may remain on this should this be their choice following discussion regarding potential risks.

Commencement involves daily assessment and titration to reach optimum dose.

The rationale for commencing substitute prescribing:

- Prevents mother and fetus experiencing withdrawal symptoms during pregnancy if taken as prescribed
- Reduces the risks from injecting behaviour
- Reduces the risks from taking unknown substances
- Helps the mother withdraw from other drug users
- Reduces involvement in crimes related to drug use
- Provides stability and engagement with services
- Usually improves nutritional intake
- Time previously spent seeking drugs can be used to focus on own needs and prepare for the baby's arrival

Substitute prescribing programmes have contributed to rapid and substantial improvements in the time that service users spend focusing on their family and home life.

The clinical team should highlight to women the advantages of substitute prescribing during pregnancy but should recognise that some women may choose to refuse treatment. In this situation, robust assessment of the woman's circumstances will determine the level of risk to the unborn child and any other children she may have.

Support and advice is offered as an integral part of substitute prescribing to provide time to explore past/present drug use and how to implement changes, deal with on-going problems without resorting to using, and provide time to reinforce progress or discuss concerns. Random drug screening is an integral part of prescribing and can be an indicator of safe compliance with medication.

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6. The Challenges

Collation of data around pregnancy and smoking, alcohol and drug use is improving however relies on women self-reporting in many cases. In 2013, 18.4% of women in Scotland reported smoking at booking but it is difficult to gain an accurate picture of smoking rates amongst pregnant women. Shipton, Tappin et al, (2009) concludes that reliance on self-reported smoking will lead to a significant number of pregnant smokers going undetected and missing out on the opportunity of specialist support.

The SMR02 (Scottish Morbidity record – Maternity Discharges) enables information regarding smoking, alcohol consumption and drug misuse during pregnancy to be recorded. Questions in the SMR02 concerning weekly alcohol consumption and drug misuse are optional and consequently not always recorded. The Data Quality Assurance Review recommends that these questions be made mandatory to help capture a more accurate and robust picture of alcohol and drug use during pregnancy in Scotland (ISD, 2010). However, NHS Highland midwifery audit of records in 2013 suggests 100 % compliance with completing this section and should be commended.

The completion of the form Scottish Drug Misuse database SMR25 Assessment Report for every new problem drug user, can provide more realistic statistics for Highland. Specialist drug misuse services complete the SMR25a form for a new client and the SMR25b for on-going service users.

6.1 Multiagency working and information sharing

Where a woman is known to be misusing substances, clear lines of communication, information sharing and multidisciplinary working must be in place during all stages of pregnancy and following birth. This will facilitate a comprehensive assessment of needs and risks and ensure a consistent approach to care. The Highland Practice Model (GIRFEC) approach will ensure that all children get the help they need when they need it.

For pregnant women who misuse substances it is important that they engage with services at the earliest stages in pregnancy as possible to ensure they are offered the full range of services. Their initial contacts and experiences will determine their future uptake of services and if women feel that their autonomy or their future as a parent is being threatened in any way, they are unlikely or less likely to disclose information or ask for help in the first place.

This requires skilful interviewing by staff. An open, honest and non-judgemental approach is essential to establish a relationship. An explanation of professional responsibilities regarding children/child protection is also essential to provide clarity at the beginning of any relationship.

The sharing of information, within and across services, underpins good practice and should occur where substance misuse involving alcohol or drugs is present. It is important to discuss multidisciplinary and multiagency working and the sharing of information proportionately and on a need-to-know basis at the earliest opportunity with women. Evidence has shown that women normally readily give their consent if it is explained that information sharing enables agencies to provide the best possible on-going care and support for them and their babies.

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The 'Data Sharing across the Highland Data Sharing Partnership Procedures for Practitioners' (NHS Highland 2008) provides guidance for all practitioners to support a co-ordinated and seamless approach to information sharing. It provides staff with the principles governing the sharing of information, which is essential to multi-agency working and describes responsibilities and requirements for this. When a practitioner is making a decision about whether or not to share data, the welfare of the child must be the main consideration.

The Data Sharing Partnership recommends asking two questions:

- Is data sharing in the best interests of the child (unborn baby)?
- Will the risk to the child (unborn baby) be increased by not sharing information?

Should consent for sharing information be refused it is essential to seek advice from line management and designated child protection advisors regarding subsequent management of the situation. The welfare of the unborn baby and any other children in the family is paramount. The Interagency Guidelines to Protect and Young People in Highland (2011) offer further information for staff and should be accessible when working in clinical areas.

When sharing information it is vital that all discussions and actions are well documented, including what and why information has been shared, and with whom. Advice should always be sought if there is uncertainty from Managers and CPAs.

6.2 Keeping children safe

Assessment of risk and need is fundamental in planning care and it is important that all healthcare workers consider that children (born or unborn) may be in need of protection. Many agencies within health may have contact with pregnant women and their children and this does not just include maternity and early years services. Workers in adult services including substance misuse, smoking cessation, mental health and others may be the first point of contact with pregnant women. Where there are any risks to the unborn child or any other children in the household these risks must be acted on appropriately.

"It is everyone's job to promote the safety and wellbeing of children. Every agency, manager and practitioner that works with children and their families, including services that work primarily with adults, takes responsibility for their contribution to the safety and wellbeing of children, and responding to any request for help."

(Interagency Guidelines to Protect Children and Young people in Highland, Highland Child Protection Committee, 2011: intro:1).

Maternity services provide support and care to all pregnant mothers assessing risk and need at every contact as detailed in the Pathways for Maternity Care (NHS QIS 2009). When there are additional support needs such as a woman having alcohol or drug issues then, the 'Antenatal Plan: additional support for mother and unborn baby' should be completed by the named midwife (April 2013). The plan should detail the impact any substance use is likely to have on the outcomes for the mother and her baby. Appropriate early support and intervention must be in place as soon as possible in pregnancy and certainly well before the baby's birth to ensure the best outcomes.

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The 'Antenatal Plan' assessment will supplement the information recorded in the SWHMR and provide a detailed plan and review of care. A] copy of the Antenatal Plan should be shared with the GP, obstetrician and H, and inform the 'Child's Plan' following birth.

Alcohol or drug use is not a sufficient reason to assume inadequate parenting, however for some families this will certainly be the case. Parental alcohol or drug use can have a damaging effect on the health and development of children which can begin before birth and it is vital healthcare workers remain proactive and vigilant to the children's needs.

Children can experience both emotional and physical disturbances and they may exhibit symptoms of failure to thrive and anxiety. Health professionals should recognise the importance of secure attachment for an infant's brain development. Any interruption to this can affect their psychological, social and emotional growth. This includes their life-long sense of security and ability to maintain relationships (Highland Infant Mental Health pre-birth – 3 years Best Practice Guidelines 2012).

Risk is dynamic and may change at any stage from conception onwards and therefore all professionals involved with the family need to ensure that risk is continuously evaluated. As well as risk to the unborn baby, awareness and safety of other children in the household must be the primary concern and assessment of risk must include:

- Seeing the child/children is paramount
- Assessing their developmental stage and understanding the family context in which they live
- Awareness and understanding of those who care for the child/children about the effects of substance misuse
- Awareness and understanding of the needs of families from diverse ethnic and cultural backgrounds.

Assessing risk to children should be elevated when there has been previous history of alcohol or drug use or if there are additional stresses in the family such as domestic abuse, a chaotic lifestyle, homelessness or mental health issues (NHS Health Scotland 2009). It is also important to consider the additional needs of children affected by disability or with communication difficulties.

All professionals should have knowledge and understanding of their local Child Protection Policy Guidelines and managers should ensure that their staff undertake regular Child Protection training relevant to their post at least every 3 years but more often if required. All midwives and HVs must attend Programme 1 training and also further training that focuses on working with substance misusing parents.

The training calendar is available at:
<http://www.forhighlandschildren.org/3-icstraining/>

Recently produced practitioner guidance is available to support the assessment process for children affected by alcohol and drug use *A Practitioners Guide to Getting Our Priorities Right (GOPR) – supporting children affected by parental substance misuse*
<http://www.forhighlandschildren.org/>

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6.3 Mental health

Perinatal Mental Health issues may be more common in women who use alcohol or drugs who may have used substances to deal with a history of anxiety, depression, sexual or physical abuse. This can impact on their long-term psychological, social and physical health and wellbeing and the effects of this on the mother can be devastating. Furthermore it can also have long term implications for a child's emotional, physical and social development.

At booking all pregnant women are asked a series of questions about their own mental health and that of their immediate family within the SWHMR. On-going assessment of their mental health is made throughout pregnancy. If a woman requires additional support this may be in the form of early intervention or may require a referral to mental health services.

Any past history of severe or enduring mental health issues will indicate that a woman's care must be managed by an obstetrician and mental health services. Any risks to the mother or baby must be discussed with the HV and GP who should be included in any planning of care for mother and baby.

The NHS Highland *Perinatal Mental Health Good Practice Guidelines (2008)* provide practitioners with more detailed information that can guide staff to ensure that the care of pregnant and newly delivered women is assessed and managed effectively

6.4 Domestic abuse

Far from being a time of peace and safety for a woman, over a third of women experiencing domestic abuse from their male partner have reported that the abuse began during pregnancy.

A woman who is misusing alcohol or drugs may also be experiencing domestic abuse and for a woman who already has a low self-esteem, the power and control that is demonstrated in domestic abuse will further add to her feelings of worthlessness and despair. Routine questioning about abuse which may be physical, sexual or emotional (including financial) must be included at booking or at another opportune time during the antenatal period. Women must always be given the opportunity to be seen on their own at least once during pregnancy to enable discussion or disclosure. Open ended questioning and reflective listening should be employed.

Multiagency training on Violence Against Women is available to all staff in Highland and training programmes are available on the NHS intranet site and For Highland Children website.

The Highland *Domestic Abuse: Pregnancy and the Early Years* protocol will be useful for staff

6.5 Cultural issues

It is very important to consider specific needs in relation to language and cultural norms and this is particularly important when working with women from Black and Minority Ethnic Communities (BME). Although most evidence indicates that many of the health issues experienced by women from BME Communities are similar to those of women in the wider community it is often the case that their experience of health services is not always as comparable.

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It is important not to make any uninformed judgements about a woman's needs and it is always appropriate to ask each woman about their ethnicity and any cultural needs they might have. It is best practice to record the ethnicity of all women using services in the SWHMR.

Many women using maternity and early year's services will need appropriate communication support. It is essential that professional interpreters are used where needed. It is generally unacceptable to use family or friends. Many of the written resources used in maternity and early years are available in alternative languages and formats and should be available on the NHS Highland website. Where the needed resources are not available in the correct language, the guidance on obtaining translated information should be followed. If a woman does not have English as her preferred language then an interpreter should always be booked or the telephone interpretation service used. Global interpretation services can be booked on 01463 258839.

For full details on how to use any of the communication support services, please see the guidance available

NHS

<http://intranet.nhsh.scot.nhs.uk/Staff/EqualityAndDiversity/Pages/Default.aspx>

The Highland Council

http://ntintra1/cx/service_management/cxoffice/policy_unit/equalopps/interpretation-and-translation.htm

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7. The Woman's Journey

When a woman becomes pregnant she may experience a range of emotions from happiness and excitement to shock and anxiety. Women who misuse drugs and alcohol are no different. There may be initial ambivalence towards the pregnancy and they will need time, information and support to enable them to make the right choices. Should they opt to continue with the pregnancy it can be a catalyst to motivate them to change their alcohol or drug use and lifestyle and accept help. People who are dependent on alcohol or drugs may have been using for several years and may have tried to stop several times. This is normal and change is a process that can take time. However, pregnancy can provide the motivation to reduce their use, if not to give up.

If women have a long-term problem it may be wrong to assume that pregnancy is the right time to stop. However, they can be offered help and information and most importantly, can still be supported to ensure that their behaviour is less risky. It is unrealistic to expect all women to detoxify during pregnancy and important to respect and support them in their choices.

To engage women more easily it is important that inappropriate service design does not compromise good practice. The lifestyle of someone using alcohol or drugs may be chaotic due to the demands of having to maintain their alcohol or drug use and additional associated problems such as financial difficulties, relationship problems, domestic abuse and homelessness. Social Work Services and the criminal justice system might also already be involved.

Families affected by substance misuse will require a multiagency, holistic approach and services must keep the safety and priority of children their priority. By reducing the need for multiple appointments that women may find hard to keep, and considering the option of afternoon sessions, women are more likely to engage with services. Good communication between practitioners across services is essential to provide safe and effective care.

7.1. Antenatal care and booking appointment

To ensure high quality maternity care, good history taking is vital and the booking appointment provides an ideal opportunity to:

- identify specific needs or pressures a family may have
- initiate a relationship with the woman
- gather information to inform the assessment process.

Those providing antenatal care should ask sensitively but routinely about all substance use, prescribed and non-prescribed, legal and illegal as detailed in the SWHMR. There may be other professionals and agencies already involved in supporting women and their families, and therefore it is important to ask about other service input such as Community Psychiatric Nurse (CPN), Drug and Alcohol Services, support worker, social worker, Councils on Alcohol, Alcoholics Anonymous, housing or others.

In Highland, the woman's named community midwife is often the first point of contact in pregnancy however, some women will make initial contact with their GP. Questions about smoking, alcohol and drug use are asked about at the booking appointment and it is

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important that any previous history of a woman's substance use is communicated between midwives, GPs and maternity services so that an accurate assessment of the likely impact on her and her baby/other children can be made. Adult services who may already be working with women must encourage engagement with maternity services as early as possible and understand the need to share information to ensure safety of mother and baby.

Some women may be known to substance misuse services but others, especially non-dependent users, may be disclosing their use for the first time. They should be given appropriate information on harm reduction which may lead to a change in their drug use (Whittaker 2003).

The booking appointment begins the process of risk assessment but risk is dynamic and may change over time therefore continued vigilance is required throughout pregnancy, labour and the postnatal period. Risk assessment should take into account factors that may affect the woman's ability to care for her baby.

It is important that a clear pathway of care is in place for all professionals involved with women who misuse drugs or alcohol. The Care Schedule provides practitioners with a minimum number of expected contacts that pregnant women will receive however, individual assessment may highlight the need for many more contacts.

If the woman's named midwife is on a period of leave or absence then her caseload must be allocated to another named member of the team who will hold responsibility. If there are child protection concerns then social work must be informed and Child Protection Procedures followed.

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28 weeks	<ul style="list-style-type: none"> • On-going assessment of substance misuse and engagement with specialist services • Pre-birth planning meeting to re-assess social circumstances/risk - update Antenatal Plan/Child's Plan/Child Protection Child's Plan as required. This will include all partners to the Plan and should also include the HV who will provide on-going care and assessment. • Named Midwife to undertake additional appointments as required which must include home assessment (consider lone working policy). • Preparation for parenthood, labour and delivery. • Give details of Family Solutions/Family Group Conferencing from Children Ist.
31- 32 weeks	<ul style="list-style-type: none"> • Discuss birth plan • Reiterate Neonatal Abstinence Scoring System (NAS). Offer visit to SCBU. • Complete Infant Feeding Checklist. • Discuss contraception and give contraception leaflets – promote (LAC).
34 - 36 weeks 37 - 38 weeks 39 - 40 weeks	<ul style="list-style-type: none"> • Assessment of substance misuse and continued engagement with specialist services. • Update Plan • Close liaison with HV as per handover protocol. • HV to undertake antenatal contact which must include home visit where alcohol or drug misuse has been identified • Continue preparation for parenthood including discussion regarding Sudden Infant Death Syndrome. • On-going discussion regarding contraception.
Labour	<ul style="list-style-type: none"> • If there are issues of substance misuse deliver in Consultant Led Unit with paediatric facilities. • Inform Named Midwife and Lead Professional on admission and delivery. • Do not give Naloxone to baby as it will induce an abrupt opiate withdrawal crisis and use supportive measures or ventilation.
Delivery	<ul style="list-style-type: none"> • Hepatitis B vaccine for baby as per protocol. • Neonatal Abstinence Syndrome (NAS) assessment and care ensuring mother is aware of the signs. • Offer support regarding infant feeding including Infant Feeding Support Worker and peers. • Accurate documentation and record keeping are essential. • Monitor substance misuse. Organise discharge prescription and follow up from specialist services (relapse prevention support). • Administer contraception prior to discharge if possible (LAC). • Discharge arrangements from hospital should be completed as per Child's Plan including Core Group meeting prior to discharge. Copies of discharge arrangements to CMW/GP/HV and others involved in the plan.
Postnatal	<ul style="list-style-type: none"> • Continue to offer multidisciplinary support to woman and her baby. • Be aware of NAS and encourage mother to continue to be observant • Ensure MW to HV handover protocol is followed. • Close assessment and support by the HV and GP must continue. • Follow up Hepatitis B immunisation for baby at 1 month old as per protocol. • Give details of Family Solutions/Family Group Conferencing and other support. • Offer referral to specialist breastfeeding services if required.

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7.3 Booking bloods

It is important to obtain booking bloods at an early contact with women but professionals should be sensitive to the fact that having blood taken may cause distress to women who are trying to discontinue their intravenous drug use.

Your Guide to Screening Tests during Pregnancy (NHS Health Scotland 2015) should be given to all women on confirmation of pregnancy. A pre-test discussion should take place and the woman should be asked to sign a consent form before testing. Current booking bloods include testing for:

- Blood group and Rhesus Factor
- Full blood count
- Rubella status
- Syphilis
- Hepatitis B Virus (HBV)
- Human Immunodeficiency Virus (HIV).

7.3.1 Blood borne viruses (BBV)

BBV may be a particular concern when working with this client group and it is important that appropriate screening and practice protocols are followed to ensure that women, their partners, their babies and their care givers are protected against BBV.

HBV and HIV can be transmitted by heterosexual intercourse. Women who are not injecting may have a partner who is and are therefore at risk of infection. HBV is easily transmitted by both sexual contact or sharing injecting equipment.

Hepatitis B immunisation has been recommended for current injecting drug users for many years but because drug users are at particular risk of acquiring HBV, vaccination is also recommended for the following:

- those who inject intermittently
- those who are likely to 'progress' to injecting e.g. those who are currently smoking heroin/and or crack cocaine and heavily dependent amphetamine users
- non-injecting users who are living with current injectors
- sexual partners of injecting users
- children of injectors including new born babies
- children of hepatitis C positive mothers
- children whose mother is HBV positive

HIV can be passed from mother to baby either during pregnancy, labour and delivery or through breastfeeding. In most cases, HIV is thought to be transmitted during the last few weeks of pregnancy or during delivery however the risks can be reduced by appropriate treatment (NAM 2011). There is now routine antenatal testing for HIV across Scotland. Clinical management of HIV positive women should be provided in accordance with national and local protocols and staff in ward areas should have access to Screening for Communicable Diseases in Pregnancy NHS Highland, 2015. The Highland policy is available on the intranet.

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Hepatitis C (HCV) is not easily transmitted through sexual intercourse. The incidence is around 6%, although sexual practices that involve blood-to-blood contact would increase risk. HCV is easily transmitted through injecting drug use and 57% of IV drug users are infected with HCV. Testing for HCV should be considered for anyone with one of the following criteria:

- history of injecting drug use
- child with an HCV antibody positive mother
- HIV positive
- otherwise unexplained persistently elevated alanine aminotransferase
- recipients of blood clotting factor concentrates prior to 1987
- recipients of blood and blood components before September 1991 and organ/tissue transplants in the UK before 1992
- had a sexual partner/household contact who is HCV infected
- had a tattoo or body piercing in circumstances where infection control procedure is suboptimal
- received medical/dental treatment in a country where HCV is common and infection control may be poor
- a healthcare worker following percutaneous or mucous membrane exposure to blood suspected to be/or infected with HCV

SIGN 2013

Although screening for HCV does not yet form part of national screening for pregnancy, NHS Highland recommends screening women who meet any of the above criteria (NHS Highland 2015).

Anyone found to be BBV positive should be referred to the appropriate specialist service:

HIV

- Highland Sexual Health. Tel: 01463 704202
- A&B CHP Sexual Health. Tel: 01546 605672

HBV and HCV

- Highland Viral Hepatitis Service. Tel: 01463 706642
- A&B residents will be referred to the appropriate service within Greater Glasgow and Clyde.

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7.4 Role of the wider maternity team

Women with a history of alcohol and/or drug misuse within the last 12 months will require additional support and obstetric led care (NHS QIS 2009). Women will be given details about the pattern of antenatal care that best suits their needs and offered further screening and surveillance appropriate to their stage of pregnancy.

An obstetrician should see all women who misuse alcohol or drugs at their initial hospital visit and on-going follow up and assessment should be discussed with a clear plan of care in place. The related medical and social problems that may be associated with a woman's substance misuse may mean that her pregnancy will be high risk.

Although most pregnant women in Highland receive the majority of their antenatal care within the community, this client group may also require additional support from specialist services as previously discussed. Information leaflets and contact numbers should be given to women who are identified as requiring extra support and are detailed in Appendix 2.

7.5 Continuing antenatal care

Routine antenatal care should be provided in the woman's locality when possible and should include regular liaison with specialist services. Care should be individualised and informed by an integrated assessment of risks and needs and should include:

- Provision of information and education about general health including nutrition and dental care.
- Home visits to allow for adequate discussion and to ensure the home circumstances are assessed.
- Information about local support agencies, benefits and allowances.
- Time to discuss any concerns and reinforce progress on substance misuse.
- On-going multiagency collaboration and communication.
- Discussion of drug use and potential effects during pregnancy and on the newborn. An explanation of NAS and the use of the NAS System Assessment Form (Appendix 3).
- Preparation for parenthood, including discussion of pain relief during labour, breastfeeding, social support, partner's role.
- Sudden infant death syndrome.
- Visit to, Special Care Baby Unit (SCBU) services.

Liaison with the family's HV is essential to ensure that the agreed support is maintained through the transition from midwifery to health visiting care. *The Procedure for the Communication and Handover of Health and Social Information between Midwife and Health Visitor* highlights that this communication process should take place from booking (NHS Highland 2014).

Any assessments should be shared with the HV who should prioritise a home visit for families with substance misuse issues, which could be a joint visit with the midwife. The importance of building relationships and establishing trust with professionals who will be supporting the family in the postnatal period cannot be overstated. The need for child protection measures should be

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regularly reviewed throughout the antenatal period to ensure that supportive measures are in place prior to the birth of the child.

7.6 Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) can occur in infants born to mothers dependent on certain drugs including opioids, benzodiazepines, alcohol and barbiturates. It is characterised by central nervous system irritability, gastrointestinal problems and autonomic hyperactivity and symptoms normally present within the first 24-72 hours after birth, but may occur up to 7-10 days later.

There appears to be little correlation between the amount of maternal drug use and the severity of NAS but certain drugs do intensify the signs. Women will be expected to remain in hospital with their baby for a minimum of 5 days after birth as withdrawal symptoms are often not evident before this time. Practitioners should be aware of the signs and symptoms of NAS in the newborn, as not all maternal drug use may have been reported and use the scoring sheet (Appendix 3).

It is very important that signs and symptoms of NAS are discussed with a woman well before her baby is due as these babies are often born premature. *Caring for a Baby with Drug Withdrawals* (see Appendix 4) can be used to support this discussion. A NAS leaflet has been developed for women whose baby develops NAS which can be downloaded via NHS providers at

<http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/HospitalPaediatrics/Documents/Neonatal%20Unit/Maternal%20disorders%20affecting%20newborn/Neonatal%20abstinence/Parenatal%20information%20Neonatal%20Abstinence%20Syndrome.doc>

Further information about the more severe range of signs and symptoms that have been reported in babies born to opiate and benzodiazepine dependent women are included in Appendix 1.

It is important to assess all infants with the use of the NAS score sheet and ensure paediatric involvement if required. The assessment should be carried out twice a day after feeding which will reduce the bias that may occur if the baby were hungry. All babies who present with NAS will be referred to Social Work Services for assessment, support and follow-up. Neonatal Liaison staff from SCBU will also follow-up babies admitted for treatment for withdrawals.

Community midwives, HVs and GPs should remain vigilant for NAS following discharge and mothers should be made fully aware of the signs which they should report to a health professional.

The NHS Highland policy should be referred to if required and the link is available at <http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/HospitalPaediatrics/Documents/Neonatal%20Unit/Maternal%20disorders%20affecting%20newborn/Neonatal%20abstinence/Management%20of%20Infants%20of%20Substance%20Abusing%20Mothers.doc>

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7.7 Missed appointments

All those involved in providing support in the antenatal period should ensure that any missed appointments are communicated between services and documented in the chronology section of the woman's records. Steps should be taken to address reasons for non-attendance and to determine whether it is appropriate to provide support to promote attendance at appointments. Community Midwives, Community Psychiatric Nurses for Addictions (CPNA) and Community Addiction Nurses are able to offer follow-up at home and provide a vital link between services. It should however be explained from the outset that if appointments are not kept, professionals involved will become concerned about the family as compliance is seen as part of the support being offered.

The named midwife must seek advice from designated Child Protection Advisors (CPA) and discuss concerns with Social Work Services. Missed appointments may be an indicator of increased risk and consideration.

7.8 Ultrasound scans

As well as being offered an ultrasound scan to determine gestation, all women in Highland are now given the option of a structural fetal anomaly scan at 18+0 - 20+6 weeks gestation. Substance misuse can be associated with structural fetal abnormality, particularly with alcohol consumption, benzodiazepine use in the first trimester and cocaine or amphetamine use. Further ultrasound monitoring in pregnancy may be required when an anomaly is detected, fetal growth restriction is suspected or other factors have contributed to concern for fetal wellbeing.

While some women will be reassured by frequent scanning and may request it, for others it may reinforce a fear that their drug use is adversely affecting their baby's wellbeing, increasing anxiety and feelings of guilt.

7.9 Pre-birth planning meeting

A pre-birth planning meeting must take place at 28 weeks gestation or as soon as possible after this following any concerns of substance misuse. This review provides the opportunity to reassess social circumstances and risk. All partners to the plan should be invited and the Lead Professional role should be clear. All practitioners who are involved in supporting the family should also take part in the pre-birth planning meeting and may have an active role as a partner to the plan (Antenatal or Childs).

The HV should be invited to meetings regarding substance misusing parents and women and families should be involved and supported to take an active role in the meeting and agencies should act as a team and work together seamlessly. The assessment should include:

- Accommodation and home environment
- Provision of basic necessities, financial situation
- Physical health risks
- Family's social network and support systems
- Clear discussions around when intervention is necessary
- The parents' perceptions of the situation

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- History of any other children in the family that the parents may have contact with (or not)
- Attendance at appointments for antenatal care, social care, specialist drug services
- The pattern of parental drug/alcohol use and procurement
- Discussion of partner/fathers needs and any assessments required

The discussions and decisions that occur at the pre-birth planning meeting will inform the woman's individual care plan and must be documented in her medical notes in the unit where she will deliver. The Lead Professional should update the Antenatal/Child's plan. Child protection procedures must be followed when required.

7.10 Admission

Admission to hospital can be an anxious time for mothers, particularly if they have encountered difficulties and increased their drug use prior to admission. They may be frightened of experiencing withdrawal symptoms if unable to maintain their normal supply. It is important to clarify their present medication and to ascertain whether they have been using anything else on top of their prescription. If this is the case; what has been used, how often and how has it been used must be documented.

The prescriber and others involved should be phoned to advise them of admission and to receive up-to-date information on progress, present medication, dispensing arrangements and results of recent drug screening tests. The dispensing community pharmacist should be contacted to clarify whether medication has already been given for that day and the present prescription cancelled. This should prevent medication being collected by anyone else while the woman is in hospital.

Women may be admitted several times throughout pregnancy and it is important that information is kept up-to-date, including the normal dispensing times to avoid withdrawal symptoms.

Confidentiality within the ward

Some women may not want family or friends to be aware that they have been using drugs or are receiving substitute therapy, and any clinical discussions, records or dispensing should be in private.

7.11 Labour and pain relief

Most labours and births will be straightforward but babies may be born prematurely, of low birth weight or suffer withdrawal symptoms. When there are substance misuse concerns, women should give birth in a consultant led maternity unit to facilitate paediatric care. The midwives on the labour suite will provide intrapartum care and the obstetric and paediatric teams should be informed of admission, progress in labour and delivery.

The community midwife should also be informed of admission and delivery as she is the woman's main care co-ordinator. If a Lead Professional has been appointed other than the midwife they must also be informed

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For a woman with HIV the decision about mode of delivery will be made in conjunction with her, her obstetrician and HIV specialist doctor. An elective caesarean section may be recommended as the best way to prevent HIV transmission to the baby. This will depend on clinical parameters such as viral load and the use or otherwise of anti-retroviral agents. Care for babies born to women with BBV should follow the NHS Highland Protocol, Screening for Communicable Diseases in Pregnancy NHS Highland, 2015. The Highland policy is available on the intranet

<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Policy%20for%20Screening%20for%20Communicable%20Diseases%20in%20Pregnancy.pdf>

If a woman is on a substitute prescribing programme this should be continued during labour and standard analgesia should also be administered. Their daily dose will not provide adequate pain relief due to saturation of opioid receptors. Women should be reassured that they will be given adequate pain relief during labour and the options available should have been discussed antenatally. It should be remembered that some opiate users might require larger amounts of pain relief if tolerance has developed and a low threshold for epidural anaesthesia should be considered. Drug misuse is not a contraindication to the use of a patient controlled analgesia (PCA) pump following caesarean section (Whittaker 2003).

Routine care during labour should apply, with careful observation of mother and baby for signs of withdrawal or increased placental insufficiency. These may present as:

In the mother	In the baby
restlessness	bradycardia
tremors	tachycardia
sweating	increased foetal movements
abdominal pain	meconium stained liquor
cramps	
anxiety	
vomiting	

Naloxone (an opiate antagonist) must **NOT** be given to reverse opioid induced respiratory depression in the newborn, as it will induce an abrupt opiate withdrawal crisis. Supportive measures or ventilation should be used.

7.12 Postnatal care

All mothers and babies should be transferred to the postnatal ward unless there is a medical reason for admission to SCBU and separation should be avoided whenever possible. Following delivery all known drug dependent women should be encouraged to stay in hospital for a minimum of 5 days so that any signs and symptoms of NAS can be detected. Withdrawal symptoms from methadone are often not seen until then or later. The use of the NAS score sheet should have been fully explained to the mother in the antenatal period and she should be

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involved in the scoring process. This form should be kept in the ward office for reasons of confidentiality.

All babies of mothers who are injecting drugs require a course of Hepatitis B vaccine to be started as soon as possible after birth. Women can be offered Hepatitis B and Hepatitis A vaccination if appropriate. A leaflet is now available from NHS Scotland to give to women whose babies are at risk *Hepatitis B immunisation: How to protect your baby* (2013) and is available from the Health Information Resources Library (HIRS).

The multiagency team should be informed that the woman has given birth and details of her and her baby's health. If a mother insists on early discharge she should discuss this with the paediatrician as she may be taking her baby home against medical advice. In this situation advice should be sought from the local CPA. If the mother discharges herself without her baby, the baby will be transferred to SCBU.

Some babies may not require treatment but may be restless and difficult to settle. This is a time when mothers can be supported and taught skills to comfort their babies (see Appendix 4) and the NAS leaflet.

Any parent can find it difficult to meet the demands of a new baby and it is not specific to women who use drugs or alcohol. Every opportunity should be taken to help mothers learn to recognise their baby's needs and how these can be met. The play@home guidance (see Highland Information Trail) and introducing baby massage may assist mothers to feel they are positively supporting and interacting with their babies. All HV bases in Highland have a copy of 'The Social Baby' DVD which provides practical examples of parent and baby communication.

Withdrawal symptoms from methadone and benzodiazepines may not be evident until several days or weeks following birth. Parents and community staff including GPs, HVs and Community Early Years Workers caring for the family need to remain vigilant for signs of withdrawal in the baby.

7.13 Infant feeding

The benefits of breastfeeding should be discussed with all women antenatally and breastfeeding should be encouraged. Social drinking by the mother is unlikely to pose a risk to breastfed babies however, alcohol passes freely into the breast milk and peak levels appear 30 – 90 minutes following intake. Binge drinking should be avoided (Jones 2013).

If drug use is stable and the woman is on prescribed methadone, she should be informed that the advantages of breastfeeding her baby outweigh the disadvantages. Apart from well documented evidence of the benefits of breastfeeding, it may also help to reduce withdrawal symptoms experienced by the baby, as small quantities of drugs may be passed via the breast milk. If a mother is on methadone and breastfeeding then weaning should be gradual to reduce withdrawal symptoms in the neonate.

Breastfeeding can bring comfort to the mother at a time when she may experience significant guilt regarding her drug use and potential withdrawal symptoms for the baby. Skin to skin contact will help regulate the baby's temperature, heart rate and breathing, and will also reassure and comfort both mother and baby. Breastfeeding should be commenced as soon as

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possible following delivery as recommended in the Highland *Infant Feeding Policy for Midwives* (NHS Highland 2014).

The exceptions to promotion of breastfeeding are:

- If a woman is HIV positive, due to the high risk of transmission.
- If she is using large quantities of stimulant drugs such as cocaine, 'crack' or amphetamines, because of vasoconstriction effects.
- If drinking heavily or taking large amounts of non-prescribed benzodiazepines, because of sedative effects.

The advice regarding drugs and breastfeeding includes:

- Amphetamines – should be avoided recreationally when breastfeeding as there is a lack of clinical data surrounding the effects

Cocaine – is slowly metabolised and excreted over a long period and infants do not possess the enzyme necessary to metabolise cocaine and are at increased risk of its effects. Women who use cocaine should be advised to pump and discard their breast milk for 24 – 48 hours.

- Ecstasy – avoid during breastfeeding. If the mother does use she should pump and discard her milk for a minimum of 24 – 48 hours
- Marijuana – regular use should be strongly discouraged
- Diamorphine – avoid during breastfeeding. Encourage enrolment on a methadone programme.
- Methadone – generally compatible with breastfeeding but monitor baby for sedation, breathing difficulties, level of arousal. When breastfeeding stops there is a possibility that the infant may experience withdrawal. Babies exposed to methadone in-utero will be more tolerant to the drug than babies whose mothers started postnatally.

(Jones 2013)

- Buprenorphine – generally safe to take while breastfeeding. 1 study has reported slow weight gain in neonates and reduction of milk supply in women. (Hale 2012)

The injecting of drugs whilst breastfeeding should be discouraged because of the risks of BBV transmission to the baby. Women who are HBV positive can breastfeed once the baby has been given his/her first dose of Hepatitis B vaccine and immunoglobulin (HBIG) if required. These should be administered as soon as possible after birth and no longer than 24 hours later. Blood Transfusion Service (BTS) Highland recommends HBIG is given where applicable within 4 hours and all staff should refer to the Highland Policy for further clarity (*Screening for Communicable Diseases in Pregnancy for NHS Highland*). There is no evidence that the HCV is transmitted by breastfeeding and this should be conveyed to the mother.

To open up discussion about infant feeding the booklets '*Ready, Steady, Baby*' and '*Off to a Good Start*' (NHS Health Scotland 2015) available from HIRS will have been given out to all women during pregnancy, as per Highland's Information Trail. Women should be able to make an informed choice on how to feed their baby and those who decide to artificially feed should be supported in this. Further advice about bottle or mixed feeding is detailed within the NHS

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Highland publications, *postnatal breastfeeding booklet* and *postnatal formula Booklet* both detailed in the *Highland Information Trail* and available from HIRS.

7.14 Discharge planning meeting

A discharge planning meeting should be viewed as a supportive measure with the aim of discussing arrangements in place for going home, making practical arrangements for appointments and establishing where the mother and baby will be staying. The meeting should clarify for the mother and all professionals involved if there are any on-going concerns and any further help that maybe required. Where appropriate, meetings should also involve partners and an assessment of their needs as well as those of the mother, baby and any other children taken into account.

Planned support that continues into the postnatal period is crucial as this can be a stressful time for parents. For mothers who have managed to reduce their drug and alcohol use during pregnancy the risk of relapse to former levels of use is high. Relapse prevention work, careful drug management and intensive psychosocial support may be required for some time. Arrangements should be recorded in the medical notes, the Child's Plan should be updated and a copy of appointments and contact numbers given to the mother.

7.15 Contraception

Many women who use drugs and alcohol do not see contraception as a priority as they often underestimate their fertility. However, it is a priority for service providers to ensure they are offered a form of contraception which best meets their needs. It is essential that discussion takes place about reproductive health and contraception throughout pregnancy to allow informed decision making prior to postnatal discharge. Women can then be enabled to make choices regarding their future sexual health before they leave hospital following delivery as once discharged they frequently do not access services.

Provision of contraception should ideally occur prior to discharge and long acting reversible methods such as progesterone implants and intrauterine devices are an appropriate choice for this client group. These should be encouraged wherever possible.

When providing information it is important to give contact details that are relevant to the area where the woman lives and ensure that she understands the important role of her GP and Highland Sexual Health Services. Discussion should include:

- Individual's own health/contraindications
- Availability – how to access services
- Compliance
- Risk of sexually transmitted infections (STIs)
- Importance of contraceptive cover

To ensure robust follow-up and compliance, those involved in on-going care such as the GP and HV should be advised of discussions or choices made around contraception in order that it can be raised with the women to encourage uptake.

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7.16 Prior to discharge

For those women who are on a substitute prescribing programme their keyworker/prescriber should be contacted and medical staff should advise whoever will be taking over the prescribing within the community. Medical staff will need to inform the prescriber of any changes to medication and when to take over prescribing. Liaison should be done on a weekday as the woman's own GP or prescriber may not be available at weekends.

If the prescriber cannot be contacted, a maximum of a 3-day prescription could be provided when appropriate, with a community pharmacist identified, contacted and advised about arrangements. Prescriptions are issued under supervised consumption that is taken in sight of the pharmacist on the pharmacy premises or dispensed daily to be consumed elsewhere.

7.17 Continuing postnatal care

All staff should understand that the care of a pregnant woman who misuses alcohol or drugs and the safe delivery of her baby is just the beginning of her journey. Postnatal care should enable a woman and her family to make an effective transition into parenthood, and interagency communication and collaboration are essential in ensuring thorough child care risk assessment. This must include the baby or child being seen and examined regularly and also the home environment being assessed as safe.

Continuing support following discharge will be delivered primarily by the community midwife who will be the main provider of care and advice in the early postnatal period along with other agencies involved with the family. The postnatal visits may continue for an extended period following birth in order to meet the woman's needs. This will be in addition to the care provided by the HV who will undertake her primary post-birth visit between day 11 and day 15.

Practitioners should follow the *Communication and Handover of Health and Social Information between Midwife and Public Health Nurse/Health Visitor Procedure (2014)* to ensure that continuity of care is safe, consistent, timely and effective. For this client group, on-going support in the postnatal period is essential with services working together to ensure that women are supported appropriately.

Children of parents who misuse drugs and alcohol will need additional and frequent assessment and support. They must **not** follow a core pathway The HV and GP will provide continuing support to the family to ensure that the correct level of care is provided. The importance of attending baby clinics for immunisation and developmental monitoring must be emphasised to parents and any missed appointments must be followed up promptly. Any risks or concerns must be acted on and babies and children must be seen and assessed and the Named Person and/or Lead Professional if allocated must be informed.

Children whose parents have alcohol or drug issues should have their health and wellbeing assessed very frequently throughout their lives to ensure they are supported to meet their milestones and are kept safe. Any concerns should be addressed through a collaborative approach with practitioners working together to ensure the best interests of the child are paramount and the best outcomes are assured.

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Appendix 1

Drugs and their effects on pregnancy and breastfeeding

OPIATES	For example: heroin, methadone, temgesic and diconal.	
Withdrawal	Risks in Pregnancy	Withdrawal Symptoms in New born
Sweating, stomach cramps, muscular pain, runny nose, diarrhoea	<p>There is growing evidence that opiate use in pregnancy is associated with visual disorders in the infant: rates of strabismus and nystagmus in infants born to opiate using mothers are significantly greater than in matched controls. The effect is not just limited to those using illicit opiates but may also be seen in those on prescriptions.</p> <p>There is no evidence that opiates cause birth defects, but withdrawal leads to spasm of the placental blood vessels and reduction in placental blood flow resulting in low birth weight. Other factors such as poor diet and smoking can also contribute to this reduction in birth weight. If opiates are withdrawn suddenly, there is an increased risk of miscarriage, fetal distress or premature labour.</p>	Babies born to mothers who use opiates throughout pregnancy show withdrawal symptoms within three days of birth but it can be in excess of 7 days if the mother has been using methadone. Symptoms may include restlessness, shrill crying, sleeplessness, constant sucking, diarrhoea, yawning, sneezing and seizures (see Appendix 4 Neonatal Abstinence Score Sheet).
BENZO-DIAZEPINES	For example: diazepam, temazepam, nitrazepam	
Withdrawal	Risks in Pregnancy	Withdrawal Symptoms in New born
Panic attacks, distortion of perceptions, feelings of	Some studies suggest certain drugs can cause defects, such as cleft palate if used in	Babies born to mothers taking these drugs can initially be quite flat and sleep excessively. Withdrawal

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<p>unreality, sweating, restlessness and tremors. Sudden withdrawal can lead to seizures.</p>	<p>the first trimester of pregnancy.</p>	<p>symptoms that may develop later include tremor, irritability, hyper activity, frantic sucking and seizures. Symptoms may be more severe than expected from the dosage the mother is taking as benzodiazepines build up in the baby's system over time.</p>
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<p>STIMULANTS</p>	<p>For example: amphetamine, ecstasy, cocaine and crack. Dependence on stimulants is thought to be more psychological than physical, although recent evidence suggests possible long-term changes to the nervous system. Due to the adverse effects when 'coming down' from stimulant use, Users often resort to taking sedative drugs (e.g., benzodiazepines or sleeping tablets) and/or alcohol to manage symptoms.</p>	
<p>Withdrawal</p>	<p>Risks in Pregnancy</p>	<p>Withdrawal Symptoms in New born</p>
<p>Withdrawal is characterised by hunger, fatigue, periods of fitful sleep, increase in dreaming and depression- in some cases prolonged and severe.</p>	<p>There may be a link between amphetamine use and congenital abnormality but studies are limited and contradictory. Due to the vasoconstriction effects of cocaine there is an increased risk of miscarriage, placental abruption, fetal hypoxia and intrauterine death. There is some evidence of a correlation between ecstasy use in pregnancy and heart defects and limb deformities. Premature labour and low birth weight are risks associated with stimulant use.</p>	<p>There is no conclusive evidence of withdrawal symptoms in the newborn but babies can experience shrill crying and irritability.</p>

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CANNABIS

Cannabis is frequently used together with tobacco (see section 3). The risks associated with tobacco are increased as people who smoke cannabis tend to inhale more deeply and for longer resulting in increased exposure to carbon monoxide and toxins.

NEW DRUGS

New drugs appear and trends in drug use change. Drugs such as mephedrone and methedrone (not to be confused with methadone) are increasingly popular in the Highlands but, at this time, there is little evidence of the effects they have on pregnancy. Both of these are now illegal but variations appear on the market very quickly and can be easily and cheaply purchased from the internet. They tend to be very potent with users having little guidance /knowledge of how much to "safely" use. The 'highs' reported are often fast and intense with Users having to increase amounts taken very quickly to achieve the same effect. These "highs" can be combined with considerable anxiety and paranoia and often followed by psychotic symptoms, depression and tiredness. These are known as "legal highs" and are often injected.

A new stimulant called N.R.G.1 is currently popular. Like the others it will probably be made illegal as soon as possible. The 'highs' reported are often fast and intense with Users having to increase amounts taken very quickly to achieve the same effect.

There have also been specific concerns raised nationally about the risks of taking drugs called "benzo-fury" and "anhialation". Currently there is little research to evidence the effects of these drugs on pregnancy. Continued use can increase heart muscle mass and seriously affect the renal system. Anecdotally, those with mental health problems and those currently prescribed anti-psychotic medication, appear to be more adversely affected with psychosis both whilst under the influence of and when "coming down" from these drugs.

'Getting Our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse' 2003.

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**Appendix 2
Useful contacts**

Agency	Tel No
Action for Children, Inverness.	01463 717227
Alcoholics Anonymous	0845 7697555
Al-Anon/Al-Ateen Helpline 10am - 10pm	02074 030 888
Antenatal clinic, Raigmore Hospital, Inverness	01463 704278
APEX Scotland Progress2Work service, assisting recovering drug misusers back to employment	01463 717033
Benefits Agency	01463 663500
Beechwood House, Inverness	01463 711335
Childline	0800 1111
Child Protection, for info on local teams, Inverness Argyll & Bute	01463 701307 01546 604281
Children 1 st Family Solutions/Family Group Conferencing killen@children1st.org.uk	01381 620757
Citizens Advice Bureau: Inverness Nairn Ross & Cromarty East Sutherland (Golspie) Nth West Sutherland (Kinlochbervie) Caithness (Thurso) Lochaber Skye & Lochalsh Argyll & Bute	01463 237664 01667 456677 01349 883333 01408 633000 01971 521730 01847 894243 01397 705311 01478 612032 01546 605550
Cocaine Anonymous	0800 6120225
Community Midwives: Inverness. Outwith Inverness, contact GP surgery for details of local midwife.	01463 704342
Community Psychiatric Nurses for Addiction:, Inverness Argyll & Bute Addiction Team 01546 605602	01463 706973/ 706972
Community Addiction Nurses: Argyll & Bute	01546 605602
Criminal Justice Team: Inverness Dingwall Wick Argyll & Bute	01463 724022 01349 865600 01955 603161 01586 559050
Domestic Abuse National Helpline	0800 027 1234

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Directory of Highland Drug and Alcohol Services, Highland Alcohol and Drug Partnership (HDAP) www.highland-adp.org.uk Information Line Argyll & Bute	01463 704603 0844 848 3778 01546 604948
Drugline Scotland	0800 776600
Dual diagnosis Service (Community), RNI, Inverness	01463 706958
Drug & Alcohol Services, Osprey House, Inverness. Contact for local details Argyll & Bute Community Addiction Teams	01463 716888 01546 605602
Drug Treatment & Testing Order DTTO.	01463 716324
Harm Reduction Nurse, Inverness	01463 716324
Harm Reduction Nurse, Argyll & Bute	01631 571294
Health Information & Resources, HIRS, Assynt House, Beechwood Park, Inverness	01463 704647
Highland counselling services: Inverness Ross, Sutherland, Wick Lochaber Skye & Lochalsh Encompass Counselling and support, Argyll & Bute	01463 220995 01862 894097 01397 702340 01478 612633 01631 566090
Homeless Shelter, Inverness Homeless Housing Officer, Argyll & Bute Homeless Nurse, Argyll & Bute	01463 718669 01546 604673 07920 548252
Kintyre Alcohol and Drugs Advisory Service (KADAS)	01586 553555
Narcotics Anonymous	0845 373366
Osprey House, Drug and Alcohol Services, Inverness	01463 716888
Police Scotland Non-emergency number – crime or other concerns Emergency	101 999
Rape and Abuse Helpline, Dingwall (Lines open 7am-10pm)	080 8800 0123
Road to Recovery: Inverness Dingwall Muir of Ord Black Isle	01463 715809 01349 862183 01463 871223 01349 866067
Scottish Drug Misuse Database	0131 551 8221
SMART Recovery, Inverness	01463 729548
Smoking Cessation Service, Highland. Ring for details of locality numbers.	0845 757 3077
SNFAD (for parents and families of drug misusers)	0808 010 1011

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Social Work Services, Highland Council, (Emergency out of hours 08457 697284) Social Work Services Argyll & Bute (Emergency out of hours 0800 811505)	01463 703456 01631 563068
STRADA – Scottish Training on Drugs & Alcohol, www.projectSTRADA.org	0141 330 2335
Substance Misuse Co-ordinator, NHS Highland, Inverness. Information for clients and professionals	01463 704969
Scottish Women’s Aid (National)	0131 475 2372
Smoking Cessation Midwife	01463 706370 07824417514
Women’s Aid: Inverness Ross-shire Lochaber office Caithness & Sutherland Argyll & Bute	01463 220719 01349 863568 01397 705734 08454 080 151 0870 241 3548
Youth Action Team: Inverness: Nairn, Badenoch & Strathspey North, West and Mid-Highland	01463 256603 01955 605792
Websites	
www.carecommission.com www.turningpointscotland.com www.knowthescore.info www.sdf.org.uk www.drugmisuse.isdscotland.com www.clearingtheairscotland.com www.ashscotland.org.uk www.canstopsmoking.com www.streetwise-highland.org www.highland-adp.org.uk www.ab-adp.org.uk www.fasdtrust.co.uk www.alcohol-focus-scotland.org.uk www.alcoholconcern.org.uk www.downyourdrink.org.uk www.nhs24.com/alcohol www.infoscotland.com/alcohol www.smokefreehighland.co.uk	

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Appendix 3

Neonatal Abstinence Score Sheet

SYSTEM	SIGNS AND SYMPTOMS	SCORE	AM	PM	COMMENTS
CENTRAL NERVOUS SYSTEM DISTURBANCES	Excessive high pitched (or other) cry	2			Daily weight
	Continuous high pitched (or other) cry	3			
	Sleeps <1 hour after feeding	3			
	Sleeps <2 hours after feeding	2			
	Sleeps <3 hours after feeding	1			
	Hyperactive moro reflex	2			
	Markedly hyperactive moro reflex	3			
	Mild tremors disturbed	1			
	Moderate-severe tremors disturbed	2			
	Mild tremors undisturbed	3			
	Moderate-severe undisturbed tremors	4			
Increased muscle tone	2				
Excoriation (specific area)	1				
Myoclonic	3				
Generalized convulsions	5				
METABOLIC/VASOMOTOR/RESPIRATORY DISTURBANCES	Sweating	1			
	Fever < 101 (37.2-38.2° C)	1			
	Fever > 101 (38.4° C and higher)	2			
	Frequent yawning (>3-4 times/intervals)	1			
	Mottling	1			
	Nasal stuffiness	1			
	Sneezing (> 2-4 times/intervals)	1			
	Nasal flaring	2			
Respiratory rate > 60/min	1				
Respiratory rate > 60/min with retractions	2				
CASTRO-INTESTINAL DISTURBANCES	Excessive sucking	1			
	Poor feeding	2			
	Regurgitation	2			
	Projectile vomiting	3			
	Loose stools	2			
Watery stools	3				
TOTAL SCORE					
INITIALS OF SCORER					

Figure 8-2 Neonatal Abstinence Score Sheet. (From Finnegan LP: *Neonatal abstinence Syndrome* in Nelson N Editor: *Current therapy in neonatal perinatal medicine*, ed., Ontario, 1990 BC Decker)

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Appendix 4

Caring for a baby with drug withdrawals

Information for parents/carers

Babies who show symptoms of drug withdrawal may require some special care and attention from their parents. There are a number of things that you can do to help your baby which will reduce the effects of withdrawal.

Some ideas that might be helpful:

- Make sure your baby is kept in quiet and calm surroundings with no bright lights or loud sounds that might upset your baby.
- Rock your baby gently and move them gently.
- Hold your baby as much as is possible and maintain 'skin to skin' contact.
- Swaddling - can be comforting for baby when trying to soothe, but baby shouldn't be put to sleep swaddled. (In line with cot death recommendations).
- Try a gentle massage with soft background music.
- Consider using a soother to help them settle, unless you are breastfeeding.
- Change their clothing to prevent sweating.
- Use a barrier cream around the baby's bottom to prevent skin damage and also keep a close eye on the skin around their mouth especially if they are vomiting.
- Do not smoke or allow anyone else to smoke in the same room as your baby.
- Avoid overheating baby.
- Feed baby on demand, frequent small feeds will suit your baby better than giving larger feeds less frequently.
- Keep a record of all the feeds your baby takes so that your midwife/health visitor can check whether your baby is feeding well enough and putting on weight.
- If your baby has any abnormal movements/convulsions, dial 999 and ask for an ambulance to take your baby to hospital.

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Appendix 5

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Karen Mackay	Infant Feeding Advisor	NHS Highland
Roderick Maclean	Speciality Doctor in Addiction Psychiatry	NHS Highland
Lorna MacAskill	Family Nurse Partnership Nurse	NHS Highland
Lorraine McKee	Health Protection Nurse Specialist	NHS Highland
Sarah Mackenzie	Research & Intelligence Officer, Highland Alcohol and Drug Partnership	NHS Highland
Claire McPhee	Smoking Cessation Midwife	NHS Highland
Alan Richards	Advanced Neonatal Nurse Practitioner (ANNP)	NHS Highland
Debbie Stewart	Co-ordinator Highland Alcohol and Drug Partnership (HADP)	NHS Highland
Sheena Stubbs	Service Co-ordinator, Osprey House, Drug and Alcohol Centre	NHS Highland
Philine van der Heide	Consultant Paediatrician	NHS Highland

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